Appendix K

Trauma Assessment

The following is an excerpt from *The Crossroads Cross Training Manual*: *Assessment, Service Provision and Referral*, written and produced by Summit participant Lauri Nichols of the ASTOP Sexual Abuse Treatment Center, copyright 2000.

A. Suggested Interview Techniques – Trauma History

For purposes of this curriculum/resource manual and this chapter we will provide possible interview techniques for use when consumers/survivors *remember and know* they have experienced a trauma event such as physical abuse, domestic violence or sexual assault. Resource and referral information is available in the individual chapters on sexual violence, domestic violence, mental health and substance abuse. The following discussion about interview style and suggestions of strength-based approaches applies to *all* subsequent interview techniques in this chapter including substance abuse, mental illness and suicide.

Historically many consumers/survivors with trauma histories have had little trust in the public mental health system. This lack of trust, in part, stems from the medical model for providing services. The medical model of mental health services until recently has meant that consumers/survivors have had little say in their therapy or kinds of services they receive. This lack of choice and control is similar to the lack of choice or control survivors experienced when traumatized. In order to build trust, interview techniques should give choice and control over when and what information is shared or disclosed with helping professionals. Several strength-based approaches are used in trauma-related therapy to convey a value and belief about survivors, consumers, our world and violence. This value is rooted in the belief that strengths and coping strategies are necessary for survival from trauma, they are *not* deficits or pathology or "problem behaviors" and survivors are not blamed or judged. Strength-based interview techniques ask questions and make reflective statements using language of strength, for example, "where did you find the strength to get through the situation?" or "that was courageous". To reduce shame, normalize coping and provide a framework for building upon strengths, re-framing is a technique used with strength-based language, such as, "you were looking for companionship, everyone needs companionship" or "the coping strategies worked well then", or "you showed perseverance."

Asking specific questions about one's trauma experiences gives permission to talk as well as shows interest and empathy on behalf of the helping professional. For example at all times the helping professional should explain what happens next and that some difficult questions may be asked. During assessment, an

introduction statement may be useful such as, “because of the prevalence of violence in our world, some difficult questions may be asked.” OR “Because of the prevalence of sexual assault and domestic violence in our world, I’ve started asking about it routinely”. Always ask permission to ask questions, such as, “Do you mind if I ask some questions about ___?” OR “Is this a good time to ask questions about ____?” Also reassure the individual that they have control over stopping the questions, such as, “At any time we can stop or take a break, just let me know.” In the beginning it is recommended that more general questions be asked, moving to specific questions. The following illustrates examples of questions appropriate for a variety of settings, moving from a general to specific interview format that will solicit information about trauma histories as well as allow the consumer/survivor to being to tell his/her story.

> “What brings you to our agency today?” OR “Where would you like to start?”
>
> “How can our agency help you?”
>
> “I understand that you have some concerns about…can you tell me about them?”
>
> “Is there anything that you think I need to know that I haven’t asked you so far?”
>
> “Are there any areas you think we need to cover more thoroughly?”
>
> “Have you ever had an experience you thought to be traumatic?”
>
> “Can you tell me what happened to you?” OR “What did you do to survive or get through….?”
>
> “Have you ever had an experience where you thought you might die or be seriously injured?”
>
> “Have you ever had an unwanted sexual experience?” “Have you every been physically hurt by another person?” “Have you ever witnessed or seen someone killed or seriously injured by another?”
>
> “As a child or teen did anyone touch you sexually or make you have sex?” “As a child did you see your parents fight, did they hit, push, shove or call names?” “How did you know your parent(s) was angry at you when you were a kid, did they ever hit you, call names… etc.?”
>
> “Every couple has disagreements or fights, what are disagreements and fights like in your household? Do they ever become physical?”

"Are you having any extra stress with your spouse (partner, work)?" "Are you ever afraid of your partner (spouse or someone at work)?" "You mentioned that your partner uses drugs/drinks. What happens when he/she does?" "You mention that your partner has a temper, what happens when he/she gets angry?"

"Has your partner (spouse or someone at work) ever hurt you, threatened to hurt you?" "Did someone hit you?" "Was it your spouse (partner)?"

"I'm concerned that what you have told me so far may have been caused by someone hurting you. Has someone hurt you?" "Many persons who come to this agency tell me that someone close to them has hurt them. Could this be happening to you?"

"Have you ever been in a situation similar or like this one?"

It is important when asking the above questions, to avoid an atmosphere of cross-examination and emotional flooding of the survivor. The goal is to allow the consumer/survivor to initiate a narrative disclosure of trauma, at a comfortable and safe pace. During the unfolding narrative, the interviewer asks key questions and makes reflective statements to clarify and support the disclosure. By using re-framing and strength-based techniques the helping professional establishes trust and connects with the consumer/survivor. Signs of emotional "flooding" must be respected and checked out with the survivor. Emotional flooding may result in consumers/survivors withdrawing or failing to attend sessions, increased feelings of hopelessness or increased trauma responses such as nightmares, self-injury, etc.

Most helping professionals, at some point in their work will make judgments about the authenticity of a survivor's report of abuse. There are no valid or tested guidelines that help judge the credibility of trauma stories. Credibility decisions may in fact predispose professionals to certain disbeliefs that will interfere in the helping relationship. For example, the professional who does not believe in dissociative identity disorder (DID) will not listen to his/her clients concerns about hearing voices or may misdiagnose the client, leading to further re-traumatization. Professionals who have strong beliefs or find they do not believe trauma stories should refrain from providing trauma work and refer the individual on to another helper.

B. Suggested Interview Techniques for Assessment of Substance Abuse

In several studies, 23% to 76% of consumers with post trauma stress disorder (PTSD) also have a diagnosis of alcohol abuse (Everly & Lating, 1994). On average alcohol abuse occurs in approximately 30% of those with PTSD, and thus should always be assessed (McFarlane, 1994). Penk (1993) states that

"substance abuse successfully masks or controls PTSD symptoms." Rape survivors are 3.4 times more likely than non-survivors to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other hard drugs (Rape in America: Report to the Nation, 1992). Survivors may use substances to medicate and numb themselves following sexual assault. The reaction of trying to manage the effects of trauma by numbing or medicating is a *normal* trauma response. Many women and men survivors in recovery continue to relapse until they have dealt with their sexual abuse issues. Alcohol and drug abuse counselors know that recovery from substance dependency is a process rather than a single event. The majority of persons in recovery appear to have relapses with eventual longer periods of abstinence on the road to recovery.

Survivors who relapse from substance abuse have additional feelings of shame. Unfortunately, *traditional* models of substance abuse recovery programs have often discharged women who relapse and outpatient programs have refused to provide services to women who continue to use substances. Recently nontraditional recovery programs for women have been developed that recognize the relationship between trauma and substance recovery and shame. These programs provide holistic services to women and their children, and do not discharge or refuse services because of relapse or ongoing substance use. Another issue related to traditional alcohol and drug abuse programs evolved around the use of prescribed medication during recovery. In the past it was thought that the use of any substance, whether prescription or not that affected an individual's feelings or emotions was contrary to recovery. Today, the benefits of non-addicting psychotropic medications are combined with trauma-related therapy for survivors who are also recovering from substance abuse.

In this section we will suggest possible questions for helping professionals who are *not* alcohol and drug abuse counselors. These questions will assist in assessing substance use and help determine when a consumer/survivor may benefit from a referral for an alcohol/drug abuse assessment/therapy. Similar to the previous section about interviewing techniques for trauma history, a strength-based approach that allows choice and control is recommended. It is also recommended that professionals begin with asking general questions during assessment and service provision as well as follow-up questions with consumers/survivors mention their drinking or use of substances. An example of a general question is "Do you have any habits or behaviors that would be good to change?" "What are some behaviors or habits that others would like you to change?" "Sometimes persons who have been sexually abused develop coping strategies to help them get through the day, like using alcohol or drugs, do you use drugs or alcohol?" More specific questions might include:

"Do you feel that you drink/use drugs too much?"

"Are you able to stop drinking/using drugs when you want to?"

"Does anyone close to you complain about your drinking/use of drugs?"

"How does your partner, spouse, children, employer, friends, etc. feel about your alcohol/drug use?"

"When and how much do you use alcohol/drugs, i.e. in the morning, over the lunch hour, after work, week-ends, five shots of brandy each night, ten beers on the week-ends?"

"Have you ever been told by a doctor to stop drinking or using drugs?"

"Have you ever been in a hospital because of your drinking or use of drugs?" and,

"Have you every been arrested or had any tickets because of your drinking/use of drugs?"

The above questions will give important information about how the survivor is using substances, the frequency and prevalence of use. Reliance on substances to get through the day may be a high-risk warning sign for dependence. The hindrance of substances in one's life, i.e. work, family and health is also another high-risk sign for dependence. Seven specific signs of alcoholism are: increased or decreased tolerance in consuming alcohol; withdrawal symptoms; unintended use and a compulsion to use even thought the person wants to stop; daily use; alcohol consumption interferes with work, family and other areas of one's life.

It is important to note that the use of substances increases one's risk for further violence, as well as the potential for criminal behavior. Therefore, re-interviewing the client throughout service provision around additional substance abuse related trauma and a criminal history might be necessary.

C. Suggested Interview Techniques for Assessment of PTSD, Mental Illness and Suicide Risk

Post traumatic stress disorder or PTSD involves several key reactions and behaviors, including re-experiencing the event through flashbacks, intrusive thoughts or nightmares, hypervigilance, difficulty concentrating, fear and anxiety and mood disruption including depression and anger. The purpose of this section is to provide a *general*, non-diagnostic guide for all types of helping professionals. Possible questions are suggested to help determine when a referral for mental health assessment or treatment may be appropriate for a survivor. Individuals can experience short-term or longer-term post trauma stress reactions and behaviors. The short-term post trauma reactions are those that are common and normal responses to a trauma event. Normalizing these reactions is helpful for the individual. Short-term stress reactions can last up to

three months following a trauma event. Longer-term post trauma reactions are those that have developed beyond three months after an event and become chronic or a part of the individual's day to day coping. When assessing for PTSD is it important to try to determine what the individual's life functioning was prior to the trauma event. The following are examples of strength-based questions that may solicit information suggesting possible PTSD and the need for a mental health referral:

> "What is the most significant result in your life from ____?" OR "How were things in your life before ____ happened, how are they now?"
>
> "Do you have memories, thoughts or images about what happened come into your mind when you don't want them to?" "How often does this happen, does this interfere with what you are doing, how?"
>
> "Do you blame yourself or anyone else for what happened?" OR "Do you ever go over what happened and find yourself thinking, if only I had…..?"
>
> "Do you have any sleeping difficulties, what are they?" (i.e., nightmares, waking several times in the night, fear of falling asleep) "Tell me about your dreams and nightmares."
>
> "Because of _____ are there any situations that you now avoid?"
>
> "Has your health changed since _____?" "Are you eating okay?" "Tell me about your eating habits now."
>
> "Do you feel sad, have less energy, and find it more difficult to: go to work, school, be with friends, do tasks about your home?" "Do you feel irritable, have outburst of anger, sleep or cry more often now?"
>
> "Have you noticed any changes in your concentration at school, work, etc.?" "Can you read a book or watch TV?"
>
> "How are your relationships with: partner, spouse, children, family, friends, co-workers?" "Do you find it difficult to be around them, can you be close to them, do you still trust them?"
>
> "Do you use alcohol or drugs to help you cope with your stress, how does it help, how often do you use it?" "Do you do any self-harming, such as cutting, burning, pulling hair, does it help, and how often do you use it?" "Do you use any other ways to help you cope, what are they?"

Next we will provide some observations and questions that are appropriate to ask trauma survivors when exploring the possibility of mental illness. Observations of the consumer/survivor's mood, affect, and behaviors are helpful and a necessary

part of evaluating for mental illness. Possible indicators of mood/affect may include: lack of direct eye contact; staring or looking blank or gazed for periods of time; agitation; flat and depressed affect; affect or behavior that does not change or respond to changes in one's environment; affect and/or behavior that is out of context for the situation, for example, laughing when the topic or situation calls for crying; undue fear or worry; suspicion or paranoia; and disorganized or fragmented thoughts and speech.

The following suggested *general* questions might be asked using strength-based language giving choice and control in disclosing information. Because mental illness may be genetically predisposed it is important to ask questions about chronic emotional difficulties or mental illness in one's family. Most survivors who suffer from mental illness usually have a prior history of counseling, therapy, hospitalization or medication use. Sometimes this history may be complex; therefore it is helpful to ask questions over specific periods of time in the survivor's life. If the survivor is taking medication, asking questions about what the medication is and who prescribed it are also helpful in exploring if a psychiatrist or a family doctor is involved.

Recurrent themes of worries or fears should solicit further questions about specific situations that cause the worries and fears, and how often the survivor experiences these feelings. At times when survivors express undue and recurring feelings of fear and suspicion, it may be necessary to ask questions about hearing voices or seeing images inside and outside of one's head. Non-mental health professionals are often concerned about asking these types of questions when consumers/survivors generally express relief when asked. Hearing voices and seeing images is often very frightening to survivors and they often express feeling like they are going crazy. When questions are not asked about voices and images, secrecy and fear is maintained. Empathizing with concerns that the survivor feels like they are going crazy may help reassure them.

When a mental health assessment is appropriate it is necessary to explain and discuss the referral with the survivor. Statements such as "I know of someone who might be able to help give us some answers about why you are feeling (or acting) this way. Would you give me permission to talk with them?" It is also helpful to share with the consumer/survivor what information you will discuss about them and include them in the choice of a referral resource.

Assessing for Suicide:

Survivors who have PTSD are at risk for suicide. Briere and Zaidi (1989) and Anderson et al (1993) report that among abused women 49% to 66% have a history of suicide attempts. Depression is a high-risk indicator for suicidal behavior, better than 80% of persons who commit suicide are depressed at the time of their attempt (Reinecke, 1994). Approximately 15% of depressed mental

health clients will ultimately commit suicide and 80% of persons who commit suicide give warning signs about their intent (Meichenbaum, 1994). The risk of suicide increases with each attempt. Gender increases general risk of suicide for example, rates are higher for men than women; higher for divorced, widowed and single individuals, and higher for men who are unemployed. Other high risk factors that must be explored with trauma survivors include the following:

- expression of suicidal thoughts
- previous suicide attempts
- suicidal plan
- availability of weapon or resources to commit suicide
- abuse of alcohol or drugs
- previous mental health treatment: depression, PTSD
- family history of suicide
- impulsive behavior
- received or perpetrated recent violence
- sense of hopelessness
- feelings of guilt and shame
- feelings of worthlessness
- social isolation

Questions of consumers/survivors should *directly ask* about suicide. For example, “Are you feeling so hopeless that you are considering suicide?” “Do you wish that you were dead?” “How often do you think about hurting or killing yourself?” “What do you hope to change or stop through suicide?” “How close have you come to hurting (killing) yourself?” When asking about past suicide attempts ask about what they tried to do, what was the result, i.e., hospitalization, and how long ago the attempt was made. Ask about times that they thought about suicide but did not attempt suicide, and what kept them from making an attempt. Questions about deterrents to suicide may include, how family/friends would feel or react; religious beliefs; giving power away to the abuser; and unfinished life business. Asking questions about a suicide plan means also asking fi the person has access to resources to complete the plan, have personal items been given away and has a suicide note been written. Even though the client may have a suicide plan, they may look at other alternatives and develop a *No Suicide Contract*.

The consumer/survivor who expresses definite intent on committing suicide should be referred for admission to an inpatient facility. But the client who is more ambivalent may be provided services through an outpatient setting. Regardless of the strength of intent or ambivalence expressed by the individual all talk of suicide *must be taken seriously*. Suicidal persons can best be helped by conveying concern and empathy, safety and support, and a positive, unambiguous stand or belief that intervention *can* make a difference. Other helpful responses are normalizing and educating about depression, exploring options other than suicide, developing a plan to remove weapons or resources,

asking the consumer/survivor not to commit suicide, reframe suicide as giving the perpetrator ultimate power and control over the survivor, and become actively involved in helping the client seek out immediate professional help. Often times the suicidal person will give permission for calling a doctor, friend or family member who can help in developing a safety plan. Or because of intent, the suicidal person may need assistance in getting to a mental health facility. During the crisis situation, while plans are being made the suicidal consumer/survivor should not be left alone. If a mental health facility is not available, calling local law enforcement may be necessary. After the appropriate intervention, follow-up with the client by asking about medication, whether he or she is continuing to see a psychiatrist or therapist. Asking the consumer/survivor if they would sign a release for the exchange of information is essential in coordinating services with the mental health provider.

Self-injury:

Self-injury is different from suicide in that it occurs when the consumer/survivor causes physical damage to their body, but the survivor does not necessarily want to die. The damage can be inflicted by hair pulling, cutting, scratching and burning, through excessive body piercing and tattoos, especially in genitals, and eating disorders. Most survivors who self-injure will hide their injuries, a few will display them.

Survivors who self-injure do so for a variety of reasons; most have learned that it serves a purpose in helping to control or manage feelings and thoughts. Therapy that addresses self-injury requires a specialized treatment approach combined with careful trauma resolution and should not be attempted by professionals who are not trained in this area. Therapists working with self-injury ask questions and explore how it is helpful and what purpose it serves. For example, does it help alleviate stress, is it important for the survivor to see blood, and what feelings does the survivor feel before, during and after self-injury. An important part of therapy to reduce or eliminate self-injury is to develop alternatives to it. For example, the survivor who needs to see blood may use markers or finger paint as an alternative. To help the survivor who uses cutting to “feel” her body, applying ice may be a useful alternative. An alternative to using self-injury to relieve tension is to teach relaxation and stress reduction techniques.

During assessment for services, agency staff should ask questions to assist in revealing self-injury. If the survivor chooses not to disclose it, then they are at least aware that the possibility exists for later discussion about it. An introduction statement to the topic of self-injury may be useful in approaching it, such as, “some survivors use self-injury, like cutting or burning or pulling hair to help them manage thoughts and feelings about the sexual abuse, do you do any of those things?” Or a more direct question may be, “do you do anything like cutting or burning to help you manage feelings?” Once the survivor acknowledges self-injury it can be more directly addressed, for example, “what do you use to cut or

burn?" "How serious have you cut or burned in the past?" "How often do you self-injure?" "Have you tried to stop, and what has happened?" "Does anyone else know about the cutting?" "When did it start and when was the last time it happened?" "Do you injure anyone else?" "Do you ever injure pets?" "Do you wish to stop it or continue and why?"

Once the survivor expresses a desire to work on the self-injury, a referral to a therapist who specializes in the area should be made. It is important to talk with the survivor about what to expect next, when information will be shared as well as including the survivor in the choice of an experienced therapist. As with all other trauma issues, the goal is to ensure choice and control for the survivor.